movements found in these cases. The asthenia, the rapid fatigue, the slight diminution of tone in certain muscles, more apparent than real, it is true, the oscillations of the body, are all favorable to the theory of Luciani, according to which the cerebellum, in the normal state, exercises upon the rest of the nervous system an influence which can be expressed by a neuro-muscular sthenic tone and static action, that is to say, a complex function by which the cerebellum augments the potential energy at the disposal of the neuromuscular apparatus (sthenic action). It increases the degree of their tension during functional pause (tonic action). It accelerates the rhythm of the elementary impulses during their functional activity and it assures the normal fusion and the regular continuity of acts. The physiological mechanism of the tremor, nystagmus, speech defect, cannot at present be explained. The following general conclusion is advanced by the authors at the end of their paper:

There exists a cerebellar affection characterized anatomically by the atrophy of the cortex of the bulbar olives, of the gray pontine substance, by the total degeneration of the middle cerebellar peduncles, by the partial degeneration of the restiform bodies, by the relative integrity of the central gray nuclei. It is an atrophy which is primary, degenerative and systematic, and not sclerotic nor inflammatory. It is clinically less well marked. It is manifested by the cerebellar syndrome common to all cerebellar atrophies. It is not hereditary nor familiar, nor congenital. It occurs at an adult age. Its etiology is obscure and it is included in the category of primary cellular atrophies. We designate it by the name of olivo-pontine-cerebellar atrophy. SCHWAB.

UN CAS DE PARALYSIE BULBAIRE SUPÉRIEURE CHRONIQUE. (A Case of Bulbar Chronic Superior Paralysis.) CHARLES HUDOVERNIG (Nouvelle Iconographie de la Salpêtrière, 13th Year, No. 5, September-October, 1900, p. 473).

A case of bulbar paralysis of superior type, very chronic in its course, without any complications and absolutely unilateral. Such cases are extremely rare, no similar case having been observed in literature. The case is as follows: A woman, aged seventeen years, had always been well. No family history; no specific or alcoholic history. At the age of eleven years it was noticed that the left eye showed a deviation to the left, which slowly increased in degree, so that it became impossible to move it to the right. At the same time the left eyelid gradually fell, so that it became more and more impossible to open the left eye. For two years the eye had been completely closed and the globe turned outward. Outside of the paralysis referred to, no other condition in respect to the cranial nerves or to the internal organs was at that time found. It is then a question of a young girl seventeen years old, without hereditary or personal antecedants; she enjoyed the best of health until the actual beginning of the disease six years ago. This began with paralysis of the left oculomotor, with deviation of the eye externally. A ptosis developed. All the branches of the third pair gradually became affected. Thus at the end of six years a total ophthalmoplegia was present. In addition to the lesion of the third pair, there was a paresis of the left facial, involving all the muscles supplied by this nerve. There was no evidence of atrophy, or the reaction of degeneration in the region supplied by the nerve.

The following are important from the standpoint of differential diagnosis: lesion in the orbit, aneurism of the carotid in the cavernous sinus, basal process, lesion of the cranial bones exercising pressure, peripheral affection, root lesion, cortical or supranuclear lesion. These were all easily excluded, chiefly on the ground of the definite anatomical distribution of the lesion, and the absence of involvement of other structures in the vicinity. The lesion in this case was, without doubt, a nuclear one, an isolated affection, limited to the nuclei of the nerves in question, that is the third and seventh, in other words, it is a chronic superior bulbar paralysis or chronic superior encephalitis. The peculiarities in the case to be especially noted are the unilateral symptoms and the long duration without complication. The possibility is granted that, if the process should extend to the bulb, its unilateral character would then disappear. SCHWAB.

ÉTAT APOPLECTIFORME, HEMIPLÉGIE ET AMBLYOPIE ALTERNES, CHEZ UN HYSTERIQUE. GENÈSE ET RÔLE DE L'IDÉE FIXE. (Apoplectiform Attack, with Hemiplegia and Crossed Amblyopia in an Hysterical Person. Beginning and Role of the Fixed Idea.) SCHERB (Archives Provinciales de Médecine, I, No. 5, pp. 329-339).

Scherb reports a case which is interesting because the hemiplegia came on without known cause, and simulated organic hemiplegia so closely that a very careful examination was necessary to establish its hysterical character.

The patient was a carpenter, 49 years of age. He was received into the hospital with a diagnosis of cerebral apoplexy. He was semi-comatose and did not reply to any question. There was a right hemiplegia. During the first night the patient tried to raise himself in bed, but fell back, as the right side was helpless. There was no vomiting and no sphincter trouble. The next day the patient was in a profound stupor and did not reply to any questions, although he would open his mouth when requested, but without projecting the tongue. The hemiplegia seemed to involve the face, as the labial folds were plainly deviated to the left. The patient's temperature was 37.8°, and 38° at night. The tongue appeared to deviate in the mouth. It was not coated, nor was the patient's face flushed or his respiration stertorous. There was no conjugate deviation of the head and the eyes; he did not look to the left toward the supposed lesion. There was an active fluttering of the eyelids. Associated with this right hemiplegia was an absolutely profound hemianesthesia of the same side, but extending only up to the neck. The anesthesia was complete to touch, pain, heat and cold. The sole of the foot, however, was sensible, and the patient moved the toes slightly when they were pricked. But the toes responded by flexion when pricked, showing that Babinski's symptom was not present. On the left side of the body there was a very lively hyperesthesia, which extended to the face. One very curious symptom present was that when the left arm, the one not paralyzed, was raised from the bed by anyone, it had a tendency to remain in that position, only falling after some seconds, a condition suggesting catalepsy. The urinalysis showed no albumin or sugar.

On the second day after admission the patient answered questions by signs with his left arm, and also made known his wants in the same manner. It was learned that the present condition began with a sudden loss of vision in the left eye, so marked that the physician who saw him at that time thought it was due to an embolus of the